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AMENDMENT TO AGREEMENT BETWEEN THE COUNTY OF SAN MATEO AND SAN MATEO COMMUNITY HEALTH AUTHORITY

THIS AMENDMENT TO THE AGREEMENT, entered into this twelfth day of December, 2017, by and between the COUNTY OF SAN MATEO, hereinafter called "County," and San Mateo Community Health Authority, hereinafter called "Contractor";

W I T N E S S E T H:

WHEREAS, pursuant to Government Code, Section 31000, County may contract with independent contractors for the furnishing of such services to or for County or any Department thereof;

WHEREAS, on January 1, 2010, the parties entered into an Agreement for the San Mateo Community Health Authority to provide health insurance to Healthy Kids members for the period of January 1, 2010 through December 31, 2012 (hereafter "the Agreement") pursuant to the San Mateo County Board of Supervisor's Resolution No. 070601; and

WHEREAS, this agreement has been amended four times since originally executed; and

WHEREAS, the parties now wish to further amend the agreement to extend the agreement from January 1, 2010 through December 31, 2017 to December 31, 2017 through September 30, 2019, increase the amount of the agreement by $7,629,485 to $46,041,627, reflect changes to Family Contribution Levels, and modify the scope of work to current State requirements;

NOW, THEREFORE, IT IS HEREBY AGREED BY THE PARTIES HERETO AS FOLLOWS:

1. All Sections and Exhibits of the agreement are amended to read as follows:

Definitions

As used in this agreement, the following terms (listed alphabetically) shall have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended.

a) **"Actual Quarterly Premium Due"** shall mean the Premium due from County to Contractor to provide coverage for Members for a quarter, based on the number of actual member months of coverage per quarter.
b) **"Administrative Costs"** shall mean a percentage of all Premiums payable to Contractor under this Agreement not greater than the percentage that administrative expenses represent of the State capitation payments for the annual Medi-Cal budget approved by the San Mateo Community Health Authority at the beginning of each fiscal year.
c) **"Authority"** shall mean the San Mateo Community Health Authority.
d) **"First 5 San Mateo"** shall mean the organization created in San Mateo County in 1998 as a result of the California Children and Families Act (Proposition 10).

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e) **"Children's Health Initiative (CHI) Coalition)"** shall mean the advisory body governed by the San Mateo Community Health Authority charge with recommendations regarding CHI related program policies and operational issues.
f) **"Copayment"** shall mean the portion of health care costs for covered services for which the member's parent or guardian has financial responsibility under the Healthy Kids Program.
g) **"Cost of Health Services"** shall mean the total fiscal year costs of providing Covered Services to Members and shall include Administrative Costs and projections to pay the costs of incurred but not reported Covered Services.
h) **"Covered Services"** shall mean those health care services and supplies which a Member is entitled to receive under Healthy Kids and which are set forth in the Healthy Kids Evidence of Coverage (Attachment A, attached hereto and hereby incorporated by reference).
i) **"Estimated Quarterly Premium Due"** shall mean the amount of premium for the projection of member months to be covered in a quarter.
j) **"Evidence of Coverage"** shall mean the document issued by the Contractor to Members that describes Covered Services and Non-Covered Services in Healthy Kids (Attachment A, attached hereto and incorporated herein by reference).
k) **"Family Contribution"** shall mean the financial contribution made by the Responsible Party on behalf of a Member of Healthy Kids for either an annual or quarterly period.
l) **"Grievance Program"** shall mean a formalized set of activities designed to provide Members and Providers, exercising their rights under applicable state and federal law, to a fair and solution-oriented process to address a perceived problem with the operations of the Contractor, including delivery and access to care, in a reasonable amount of time. This Program includes provisions for evaluation of complaints, assessments of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers.
m) **"Health Plan of San Mateo"** shall mean the health plan governed by the San Mateo Community Health Authority.
n) **"Healthy Kids"** shall mean the health insurance program for children through age 18 in families with incomes up to 400% of the Federal Poverty Level residing in San Mateo County who are ineligible for Healthy Families and Full-Scope No- Share-of-Cost Medi-Cal.
o) **"Hospital"** shall mean a licensed general acute care hospital.
p) **"Member"** shall mean a child from birth through age eighteen (18) who has been determined to be eligible by the San Mateo County Human Services Agency to receive Covered Services under Healthy Kids.
q) **"Membership Report"** shall mean a report summarizing the Healthy Kids Program membership submitted by the Contractor to County each quarter to assist in the calculation of the Total Quarterly Premium Amount due from County to Contractor.
r) **"Participating Provider"** shall mean a provider who has entered into an agreement with the Contractor to provide Covered Services to Members. The terms "Participating Provider" and "Contracting Provider" may be used interchangeably.
s) **"Premium"** shall mean amount paid by County per Member per Month, to the Contractor for providing coverage to Members under this Agreement.
t) **"Protected Health Information"** shall mean individually identifiable health information.
u) **"Provider"** shall mean any health professional or institution certified to render Covered Services to Members.
v) **"Quality Assessment and Improvement Program"** means the set of formalized activities and structure developed by the Contractor to ensure the continuous review and evaluation of quality of care, performance of medical personnel, utilization of services and facilities, and trends in Grievances filed with the Contractor through quality of care studies and other health related activities in order to make improvements in the care provided to Members.

w) **"Quarter for Premium Due"** shall mean any one of the following fixed three month periods: January 1 through March 31, April 1 through June 30, July 1 through September 30, or October 1 through December 31.
x) **"Responsible Party"** shall mean a parent, guardian, other adult, or emancipated minor of San Mateo County who has completed an application for a child for participation in and coverage by the Healthy Kids Program.
y) **"Retention Project"** shall mean those activities conducted to increase membership retention, health navigation and utilization and which are set forth in the Retention Scope of Work (Attachment B, attached hereto and incorporated herein by reference).
z) **"San Mateo County Human Services Agency (HSA)"** shall mean the agency that is part of the County of San Mateo, which has undertaken a contractual responsibility for determining eligibility for Healthy Kids.
aa) **"Total Quarterly Premium Amount"** shall mean the payment due each quarter to Contractor from County. The Quarterly Premium Amount is calculated using the Actual and Estimated Quarterly Premiums.

1) Exhibits and Attachments

The following exhibits and attachments are attached to this Agreement and incorporated into this Agreement by this reference:

Exhibit A5—Services
Exhibit B5—Payments and Rates
Exhibit C5—Act and Regulation
Attachment A—CCHIP/Healthy Kids Member Handbook and Evidence of Coverage
Attachment B—Retention Scope of Work
Attachment H—HIPAA Business Associate Requirements
Attachment I—§ 504 Compliance

2) Services to be performed by Contractor

In consideration of the payments set forth in this Agreement and in Exhibit B5, Contractor shall perform services for County in accordance with the terms, conditions, and specifications set forth in this Agreement and in Exhibit A5.

3) Payments

In consideration of the services provided by Contractor in accordance with all terms, conditions, and specifications set forth in this Agreement and in Exhibit A5, County shall make payment to Contractor based on the rates and in the manner specified in Exhibit B5. County reserves the right to withhold payment if County determines that the quantity or quality of the work performed is unacceptable. In no event shall County's total fiscal obligation under this Agreement exceed FORTY SIX MILLION FORTY ONE THOUSAND SIX HUNDRED TWENTY SEVEN DOLLARS ($46,041,627). In the event that the County makes any advance payments, Contractor agrees to refund any amounts in excess of the amount owed by the County at the time of contract termination or expiration. Contractor is not entitled to payment for work not performed as required by this agreement.

4) Term

Subject to compliance with all terms and conditions, the term of this Agreement shall be from January 1, 2010 through September 30, 2019.

5) Termination

a) Termination Without Cause. The Contractor or County may terminate the Agreement without cause upon providing the other party with sixty (60) days prior written notice and shall become effective at the end of the second month following the month in which notice is given. In the event of termination, the Contractor shall furnish the County copies of documents, reports, and studies prepared for the County under this Agreement as well as access to data for Members covered under this Agreement.

b) Termination For Cause. Either party shall have the right to terminate this Agreement for good cause upon providing thirty (30) days prior written notice to the other party. Good cause may include but not limited to the termination of the funding parties' financial contributions to the Healthy Kids Program.
   i) The party claiming the right to terminate hereunder shall set forth in the written notice of intended termination the effective date of such termination and the facts underlying its claim that there is good cause to terminate this Agreement. Termination will be effective thirty days after delivery of the termination notice.
   ii) The County may terminate this Agreement for unavailability of State funds. In this event, the County shall inform the Contractor of such unavailability as soon as it is known, and to the extent legally possible, the County shall pay all outstanding amounts due. Termination shall be effective on the last day of the month in which notification is received by the Contractor. The Contractor reserves the right to seek Premium amounts from either entities should County be unable to make Premium payments.
   iii) If the County fails to make any past-due payment within fifteen (15) days after receipt of Contractor's written notice to the County of past due amount, the Contractor may terminate this Agreement. The County shall be liable for all unpaid Premiums through the termination date. Termination shall be effective on the last day of the month following in which notice of termination is given by the Contractor.

c) Termination Based upon Inability to Perform Due to Changed Legal, Contractual, or Regulatory Circumstances. In the event there are changes effected in (1) the Contractor's Medi-Cal contract with the State of California, or (2) Healthy Kids, or (3) in the Federal Medicaid or SCHIP Programs, (4) in the Federal Medicare Program or (5) under other public or private health care insurance programs or polices, any of which changes will have a material detrimental financial effect on the operations of the County or Contractor, the County or Contractor may terminate this Agreement effective on the last day of the month following the month in which notification of intent to terminate is received. In any case where such notice is provided, both parties shall negotiate in good faith in an effort to develop a revised Agreement which, to the extent reasonably practicable under the circumstances, will adequately protect the interests of both parties and members, consistent with the changed legal, contractual or regulatory circumstances which constitute the basis for exercising this termination provision.

d) Termination of Insufficient Provider Participation. If, for any reason, the Contractor is unable to enter into or maintain service contracts with sufficient numbers of Participating Providers to assure adequate Member access to needed Covered Services, the Contractor may terminate this Agreement upon thirty (30) days written notice to the County.

e) Effect of Termination. As of the date of termination pursuant to any provision of this Agreement, this Agreement shall be no further notice or effect whatsoever, except for exception in Section (g), and each of the parties hereto shall be relieved and discharged from any of the obligations it has undertaken, except that the County shall remain liable for due, unpaid Premiums and the Contractor shall remain liable for all Benefits rendered to Members up to the date of termination and for any Covered Services covered by the term of the Premium or required by law, whichever is later, rendered hereunder after such date until such time as appropriate transfer (for other medically acceptable disposition) of Members receiving inpatient services as of the date of termination is achieved.

f) Member Notification of Termination
   i) It is the responsibility of the Contractor to notify Members of the termination of the Agreement in compliance with all applicable laws.
   ii) Termination shall not relieve the County or Contractor from any obligation incurred prior to the date of termination of this Agreement.

6) Contract Materials

At the end of this Agreement, or in the event of termination, all finished or unfinished documents, data, studies, maps, photographs, reports, and other written materials (collectively referred to as "contract materials") prepared by Contractor under this Agreement shall become the property of County and shall be promptly delivered to County. Upon termination, Contractor may make and retain a copy of such contract materials if permitted by law.

7) Relationship of Parties

a) Between County and Contractor. None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other hereunder solely for the purposes of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be construed to be the agent, the employee, or the representative of the other.

b) Between Participating Providers and Contractor. The relationship between the Contractor and Participating Providers is a contractual relationship among independent contractors. Participating Providers are not agents or employees of the Contractor nor is the Contractor or employee of any Participating Provider. Participating Providers maintain their provider-patient relationship with Members and are solely responsible to their Member patients for any health services rendered to their Member patients.

A Participating Provider's participation may be terminated at any time by either the Participating Provider or Contractor and Contractor makes no express or implied warranties or representations concerning the continue participation of any particular Provider. In no event will Contractor be liable for the negligence, wrongful acts, or omissions in a Participating Provider's delivery of services regardless of whether such services are or would be covered under this Agreement, nor will Contractor be liable for services or facilities which for any reason beyond its control are unavailable to the Member.

8) Hold Harmless

a) General Hold Harmless

i) The duty of Contractor to indemnify and save harmless as set forth by this Section shall include the duty to defend as set forth in Section 2778 of the California Civil Code.

ii) Contractor and County agree that nothing in this Agreement shall cause either party to be liable or responsible for any debt, liability, or obligation of the other party or any third party, unless such liability or responsibility is expressly assumed by the party sought to be charged therewith. Each party shall be solely responsible for and shall indemnify and hold the other party harmless against any claim or obligation for the payment of wages, salaries or other compensation (including all state, federal, and local taxes and mandatory employee benefits), insurance and voluntary employment-related or other contractual or fringe benefits as may be due or payable by the party to or on behalf of the other party's employees, agents and representatives.

b) Mutual Hold Harmless

i) It is agreed that Contractor shall defend, save harmless and indemnify County, its officers and employees from any and all claims which arise out of terms and conditions of this Agreement and which result from the negligent acts or omissions of Contractor, its officers and/or employees.

ii) It is agreed that County shall defend, save harmless, and indemnify Contractor, its officers and employees from any and all claims for injuries or damage to persons and/or property which arise out of the terms and conditions of this Agreement and which result from the negligent acts or omission of County, its officers and/or employees.

iii) In the event of concurrent negligence of County, its officers and/or employees, and Contractor, its officers and/or employees, then the liability for any and all claims for

injuries or damage to persons and/or property which arise out of terms and conditions of this Agreement shall be apportioned according to the California theory of comparative negligence.

9) Assignability and Subcontracting

a) Without the written consent of the other party, this Agreement is not assignable in whole or in part. Any assignment without the written consent of the other violates this Agreement and shall automatically terminate this Agreement.

b) All assignees, subcontractors, or consultants used by either party shall be subject to the same terms and conditions applicable to the parties to this agreement, and the party assigning or subcontracting party shall be liable assignees' or the subcontractor's acts and/or omissions.

All agreements between Contractor or County and subcontractor and/or assignee for services pursuant to this Agreement shall be in writing and shall be available for review.

10) Insurance

Upon request, each party shall furnish the other party with a certificate of insurance evidencing the required coverage set forth herein.

Bodily Injury Liability and Property Damage Liability Insurances: Each party shall maintain during the life of this Agreement such Bodily Injury Liability and Property Damage Insurance, self-insurance, or a combination thereof, as shall protect both properties from any and all claims for damages for bodily injury including accidental death, as well as any and all claims for property damage which may arise from operations under this Agreement. Such insurance shall be combined single limit bodily injury and property damage for each occurrence and shall not be less than the amount specified below.

Such insurance shall include:

1. Comprehensive General Liability $1,000,000.00
2. Motor Vehicle Liability Insurance $1,000,000.00
3. Professional Liability $2,000,000.00

a) County shall carry at its sole expense general and professional liability insurance or self-insurance of at least one million dollars ($1,000,000) per person per occurrence, three million dollars ($3,000,000) aggregate. If the County obtains one or more claims-made insurance policies to fulfill its obligations under this Section, the County will purchase or provide coverage that assures protection against claims based on acts or omissions that occur during the period of this Agreement but which are asserted after the claims-made insurance policy has expired. This insurance is against professional errors and omissions in providing services under the terms of this Agreement and is solely for the protection and interest of the County, its employees, Health Plan members and third parties.

b) Each party shall provide a certificate of insurance so that the other party shall be given immediate notice of lapse, termination, amendment or changes of coverage of any policy or insurance maintained by the other party.

11) Compliance With Laws

All services to be performed by Contractor pursuant to this Agreement shall be performed in accordance with all applicable Federal, State, County and Municipal laws, ordinances, regulations, including but not limited to appropriate licensure, certification regulations, confidentiality requirements, and applicable quality assurance regulations. Violation of the statutes and regulations, laws, including nondiscrimination provisions, shall be considered a breach of this Agreement and shall serve as a basis for termination of this Agreement as well a disqualification for future contracts with the other party.

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12) Non-Discrimination and Other Requirements

a) General Non-discrimination

No person shall be denied any services provided pursuant to this Agreement (except as limited by the scope of services) on the grounds of race, color, national origin, ancestry, age, disability (physical or mental), sex, sexual orientation, gender identity, marital or domestic partner status, religion, political beliefs or affiliation, familial or parental status (including pregnancy), medical condition (cancer-related), military service, or genetic information.

b) Equal Employment Opportunity

Contractor shall ensure equal employment opportunity based on objective standards of recruitment, classification, selection, promotion, compensation, performance evaluation, and management relations for all employees under this Agreement. Contractor's equal employment policies shall be made available to County upon request.

c) Section 504 of the Rehabilitation Act of 1973

Contractor shall comply with Section 504 of the Rehabilitation Act of 1973, as amended, which provides that no otherwise qualified individual with a disability shall, solely by reason of a disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination in the performance of any services this Agreement. This Section applies only to contractors who are providing services to members of the public under this Agreement.

d) Compliance with County's Equal Benefits Ordinance

Contractor shall comply with all laws relating to the provision of benefits to its employees and their spouses or domestic partners, including, but not limited to, such laws prohibiting discrimination in the provision of such benefits on the basis that the spouse or domestic partner of the Contractor's employee is of the same or opposite sex as the employee.

e) Discrimination Against Individuals with Disabilities

The nondiscrimination requirements of 41 C.F.R. 60-741.5(a) are incorporated into this Agreement as if fully set forth here, and Contractor and any subcontractor shall abide by the requirements of 41 C.F.R. 60–741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities.

f) History of Discrimination

Contractor certifies that no finding of discrimination has been issued in the past 365 days against Contractor by the Equal Employment Opportunity Commission, the California Department of Fair Employment and Housing, or any other investigative entity. If any finding(s) of discrimination have been issued against Contractor within the past 365 days by the Equal Employment Opportunity Commission, the California Department of Fair Employment and Housing, or other investigative entity, Contractor shall provide County with a written explanation of the outcome(s) or remedy for the discrimination prior to execution of this Agreement. Failure to comply with this Section shall constitute a material breach of this Agreement and subjects the Agreement to immediate termination at the sole option of the County.

13) Reporting; Violation of Non-discrimination Provisions

Contractor shall report to the County Manager the filing in any court or with any administrative agency of any complaint or allegation of discrimination on any of the bases prohibited by this Section of the Agreement or the Section titled "Compliance with Laws". Such duty shall include reporting of the filing of any and all charges with the Equal Employment Opportunity Commission, the California Department of Fair Employment and Housing, or any other entity charged with the investigation or adjudication of allegations covered by this subsection within 30 days of such filing, provided that within such 30 days such entity has not notified Contractor that such charges are dismissed or otherwise unfounded. Such notification shall include a general description of the circumstances involved and a general description of the kind of discrimination alleged (for example, gender-, sexual orientation-, religion-, or race-based discrimination).

Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject the Contractor to penalties, to be determined by the County Manager, including but not limited to the following:

i. termination of this Agreement;
ii. disqualification of the Contractor from being considered for or being awarded a County contract for a period of up to 3 years;
iii. liquidated damages of $2,500 per violation; and/or
iv. imposition of other appropriate contractual and civil remedies and sanctions, as determined by the County Manager.

To effectuate the provisions of this Section, the County Manager shall have the authority to offset all or any portion of the amount described in this Section against amounts due to Contractor under this Agreement or any other agreement between Contractor and County.

14) Compliance with Living Wage Ordinance

As required by Chapter 2.88 of the San Mateo County Ordinance Code, Contractor certifies all contractor(s) and subcontractor(s) obligated under this contract shall fully comply with the provisions of the County of San Mateo Living Wage Ordinance, including, but not limited to, paying all Covered Employees the current Living Wage and providing notice to all Covered Employees and Subcontractors as required under the Ordinance.

15) Compliance with County Employee Jury Service Ordinance

Contractor shall comply with Chapter 2.85 of the County's Ordinance Code, which states that Contractor shall have and adhere to a written policy providing that its employees, to the extent they are full-time employees and live in San Mateo County, shall receive from the Contractor, on an annual basis, no fewer than five days of regular pay for jury service in San Mateo County, with jury pay being provided only for each day of actual jury service. The policy may provide that such employees deposit any fees received for such jury service with Contractor or that the Contractor may deduct from an employee's regular pay the fees received for jury service in San Mateo County. By signing this Agreement, Contractor certifies that it has and adheres to a policy consistent with Chapter 2.85. For purposes of this Section, if Contractor has no employees in San Mateo County, it is sufficient for Contractor to provide the following written statement to County: "For purposes of San Mateo County's jury service ordinance, Contractor certifies that it has no full-time employees who live in San Mateo County. To the extent that it hires any such employees during the term of its Agreement with San Mateo County, Contractor shall adopt a policy that complies with Chapter 2.85 of the County's Ordinance Code." The requirements of Chapter 2.85 do not apply if this Agreement's total value listed in the Section titled "Payments", is less than one-hundred thousand dollars ($100,000), but Contractor acknowledges that Chapter 2.85's requirements will apply if this Agreement is amended such that its total value meets or exceeds that threshold amount.

16) Retention of Records; Right to Monitor and Audit

a) Inspection Rights
   i) Contractor and County agree to provide to any Federal or State department having monitoring or reviewing authority, or their appropriate audit agencies upon reasonable notice, access to and the right to examine and audit all records and documents necessary to determine compliance with relevant Federal, State, and local statutes, rules and regulations, and this Agreement, and to evaluate the quality, appropriate and timeliness of services performed.
   ii) Both parties shall maintain and preserve all records relating to this Agreement for a period of five (5) days from the termination date of this Agreement or until audit findings are resolved, whichever is greater.

a) Confidentiality of Member Information

Protected Health Information shall be provided in a manner to protect the confidentiality of member information in accordance with applicable federal and state statutes and regulations.

b) Program Monitoring and Evaluation
   i) The Contractor shall collect data pertaining to the goods and services furnished under the terms of this Agreement for each funded year and shall participate in countywide and/or statewide evaluations of the effectiveness of the County's Healthy Kids efforts, whether they occur during or after the term of this contract. The Contractor shall cooperate with any evaluator hired by the County for this purpose. The Contractor shall submit additional reports as requested by the County and agreed to by the Contractor. The Contractor will provide the County with monthly Member enrollment reports by various parameters, including but not limited to, hospital districts, age, and gender. In conjunction with the County evaluator, the Contractor will conduct a Provider survey every other year.
   ii) Within thirty (30) days of the Authority's approval of its annual audit, the Contractor will provide the County with a copy of the audit and a report listing the following information from the Contractor's previous fiscal year of Healthy Kids: (1) the Cost of Health Services for the Members, (2) the total Premiums accrued to Contractor, (3) the remainder after subtracting the Cost of Health Services for the Members from the total Premiums paid to the Contractor. The Cost of Health Services for Members will be broken down into three sub-categories: the total costs of providing Covered Services to Members, Administrative Costs, and projections to pay the costs of incurred but not reported Covered Services.
   iii) The Contractor will provide services to retain members as particularly described in Exhibit A5 to this Agreement. In consideration of said services, the County will pay the Contractor the rates set forth in Exhibit B5.

17) Merger Clause; Amendments

Should either the County or Contractor desire a change in this Agreement, that change shall be proposed in writing to the other party. The other party shall acknowledge receipt of the proposal within ten (10) calendar days of receipt of the proposal. Any proposal shall be set forth a detailed explanation of the reason and basis for the proposed change and the text of the desired amendment to this Agreement that would provide for the change. If the proposal is accepted, this Agreement shall be amended to provide for changes mutually agreed to by County and Contractor in writing.

18) Controlling Law; Venue

The validity of this Agreement and of its terms, the rights and duties of the parties under this Agreement, the interpretation of this Agreement, the performance of this Agreement, and any other dispute of any nature arising out of this Agreement shall be governed by the laws of the State of California without regard to its choice of law or conflict of law rules. Any dispute arising out of this Agreement shall be venued either in the San Mateo County Superior Court or in the United States District Court for the Northern District of California.

19) Notices

Any notice, request, demand, or other communication required or permitted under this Agreement shall be deemed to be properly given when both: (1) transmitted via facsimile to the telephone number listed below or transmitted via email to the email address listed below; and (2) sent to the physical address listed below by either being deposited in the United States mail, postage prepaid, or deposited for overnight delivery, charges prepaid, with an established overnight courier that provides a tracking number showing confirmation of receipt.

In the case of County, to:

Name/Title: Srija Srinivasan, Director, Family Health Services and Health Coverage Unit

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Address: 2000 Alameda de las Pulgas, Suite 230, San Mateo, CA 94403
Telephone: (650) 573-2095
Facsimile: (650) 578-8939
Email: ssrinivasan@smcgov.org

In the case of Contractor, to:
Name/Title: Patrick Curran
Address: 801 Gateway Boulevard, Fifth Floor, South San Francisco, CA 94080
Telephone: 650-616-2547
Facsimile: 650-616-8038
Email: pat.curran@hpsm.org

20) Electronic Signature
Both County and Contractor wish to permit this Agreement and future documents relating to this Agreement to be digitally signed in accordance with California law and County's Electronic Signature Administrative Memo. Any party to this Agreement may revoke such agreement to permit electronic signatures at any time in relation to all future documents by providing notice pursuant to this Agreement.

21) Waiver
Contractor's failure to implement, or insist upon compliance with, any provision of this Agreement or the terms of the Evidence of Coverage incorporated hereunder, at any given time or times, shall not constitute a waiver of Contractor's right to implement, or insist upon compliance with that provision at any other time or times. This includes, but is not limited, the payments of Premiums or Covered Services. This applies whether or not the circumstances are the same.

22) Claim Determinations
Contractor has complete authority to review all claims for Covered Services under this Agreement. In exercising such responsibility, Contractor shall have discretionary authority to determine whether and to what extent eligible Members are entitled to coverage and construe any disputed or doubtful terms under this Agreement. Contractor shall be deemed to have properly exercised such authority unless Contractor abuses its discretion by acting arbitrarily and capriciously.

23) Third Parties
This Agreement shall not confer any rights or obligations on third parties except as specifically provided herein.

24) Inability to Arrange Services
In the event that due to circumstances not within the reasonable control of Contractor, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Contractor's Participating Providers or entities with whom Contractor has arranged for services under this Agreement, or similar causes, the rendition of medical or Hospital benefits or other services provided under this Agreement is delayed or rendered impractical, Contractor shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid Premiums held by Contractor on the date such event occurs. Contractor is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

25) Fraudulent or Material Misstatements
If any relevant fact as to a Member is found to have been misstated, an equitable adjustment of Premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is to exist and/or remain in force.

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26) Clerical Errors

Incorrect information furnished to Contractor may be corrected, provided that Contractor has not acted to its prejudice in reliance thereon. Clerical errors or delays in keeping or reporting data relative to coverage will neither invalidate coverage which would otherwise be in force nor continue coverage which would otherwise be validly terminated nor grant additional benefits to Members if Contractor, in its sole discretion, determines that a clerical error has been made. Upon discovery of such error or delay, an adjustment of Premiums may be made. In no case will adjustments in coverage or Premiums be made for a quantity more than two months coverage and/or more than two (2) Premium due dates prior to the date Contractor is notified in writing, on a form satisfactory to Contractor, of the requested addition, deletion, or change in coverage. Such correction time limitations may not apply for retroactive situations per Exhibit B5.5.

In witness of and in agreement with this Agreement's terms, the parties, by their duly authorized representatives, affix their respective signatures:

For Contractor: San Mateo Community Health Authority/Health Plan of San Mateo

DocuSigned by:
Maya Altman
12120418B8F941A...
Contractor Signature

2/5/2018 | 2:40 PM PST
Date

Maya Altman
Contractor Name (please print)

COUNTY OF SAN MATEO

By:
President, Board of Supervisors, San Mateo County

Date:

ATTEST:

By:
Clerk of Said Board

Exhibit A5

In consideration of the payments set forth in Exhibit B5, Contractor shall provide the following services:

1) Service Overview

Contractor will employ staff to work on navigation activities of Contractor members who are between the ages of 0-18 and enrolled in Healthy Kids (HK).

The duties of staff assigned to this project will include but not be limited to:

a) Conducting welcome calls for new members to improve member understanding of their benefits, how to access health care, relevant managed care processes, and the need for members to communicate any changes to their demographic information.
b) Contacting families who are late with their HK premium payments to offer financial assistance.
c) Contacting families with returned mail and attempt to obtain updated contact information.

2) Contractor Administration Responsibilities-Eligibility and Enrollment Operations:

a) Eligibility Determination
   i) In accordance with the statutory and regulatory requirements specified in Exhibit C5 of this Agreement, the Contractor shall establish and maintain procedures to notify applicants in writing of their enrollment in CCHIP for each person being applied for within ten (10) calendar days of receipt of eligibility determination via the DEF. The procedures shall include record tracking of all notifications and shall have the ability to track date notification sent, applicant's name, and enrollment date for persons being applied for.
   ii) The Contractor shall establish and maintain procedures to notify applicants in writing of their enrollment in HK for each person being applied for within ten (10) calendar days of receipt of eligibility determination from The Health Coverage Unit (HCU). The procedures shall include record tracking of all notifications and shall have the ability to track date notification sent, applicant's name, and enrollment date for persons being applied for.
   iii) The Contractor shall establish and maintain refund procedures for premium payments from applications subsequently determined to be ineligible.

3) Enrollment and Disenrollment

a) The Contractor shall establish and maintain a CCHIP and HK Welcome Packet that shall include all necessary Program information for new subscribers. The Contractor shall send the Welcome Packet out prior to subscribers' effective dates of coverage by postal service in sufficient time to arrive prior to the effective date.

b) If a person has been determined ineligible for continued CCHIP coverage by the Contractor or by CalHEERS, the Contractor shall disenroll the person from the plan in which the person is enrolled. The Contractor's reasons for disenrollment shall include the following:
   i) The subscriber is found to no longer be eligible, or fails to provide the necessary information, during the annual eligibility review (AER) period; or
   ii) The subscriber attains an age that is no longer eligible for coverage; or
   iii) The subscriber is determined not to be a citizen, non-citizen national, or a qualified alien eligible for coverage or fails to provide required documentation within established time period; or
   iv) The applicant fails to pay the required family contribution within the established time period; or
   v) The applicant declines CCHIP in the CalHEERS application or the subscriber or parent or guardian so requests in writing; or

vi) The applicant has intentionally made false declarations in order to establish CCHIP eligibility for any subscriber; or
vii) The subscriber has died; or
viii) The subscriber reports a reduction in income that results in eligibility for a more advantageous Insurance Affordability Program and disenrollment from CCHIP.

c) If a person has been determined ineligible for continued HK coverage by the Contractor or by HCU, the Contractor shall disenroll the person from the plan in which the person is enrolled. The Contractor's reasons for disenrollment shall include the following:
i) The subscriber is found to no longer be eligible, or fails to provide the necessary information, during the annual eligibility review (AER) period; or
ii) The subscriber attains an age that is no longer eligible for coverage; or
iii) The applicant fails to pay the required family contribution within the established time period; or
iv) The applicant declines HK in the HCU application or the subscriber or parent or guardian so requests in writing; or
v) The applicant has intentionally made false declarations in order to establish HKeligibility for any subscriber; or
vi) The subscriber has died; or

d) The subscriber reports a reduction in income that results in eligibility for a more advantageous Insurance Affordability Program and disenrollment from CCHIP or HK.
e) The Contractor shall mail the applicant for any disenrolled subscribers a notice summarizing each subscriber's eligible months of creditable coverage while enrolled in CCHIP or HK and the notice shall be in accordance with the federal HIPAA requirements.

4) Change in CCHIP Enrollment Status

a) The Contractor shall administer and record any changes in enrollment status during any CCHIP or HK eligibility period. This includes the addition of new subscribers who were not eligible when the applicant applied to CCHIP or HK, disenrollment of subscribers who are no longer eligible for the CCHIP or HK, changes in subscribers' plan selections and AER evaluations.
b) The Contractor shall recalculate CCHIP or HK family contribution when adding or disenrolling a subscriber and shall bill the subscriber to reflect the revised amounts due. The recalculated family contribution shall not affect the prepaid free month that the family had qualified for prior to the adding or disenrolling a subscriber. The Contractor's data systems shall maintain accessible CCHIP or HK records including all changes in enrollment of all applicants/subscribers with the date of the enrollment status changes.

5) CCHIP or HK AER

a) The Contractor shall notify the subscriber of the plans the listed subscriber(s) are enrolled in, the current family contribution, and the twelve (12) month time period for the eligibility determination.
b) The Contractor shall notify the subscriber of the plans the listed subscriber(s) are enrolled in, the current family contribution, and the twelve (12) month time period for the eligibility determination.
c) For those subscribers determined ineligible, the CalHEERS shall send a notice that shall include the eligibility determination, disenrollment date, and an explanation of the appeal process, including the option for the subscriber to request continued coverage during the appeal process.

6) CCHIP Appeals

a) The Contractor shall require that the Contractor's plans establish and maintain appeal procedures related to health care benefits and enrollment. The Contractor's plans will be informing applicants/subscribers of their benefit and enrollment related appeal rights. CalHEERS will be informing applicants/subscribers of their right to appeal eligibility determinations to the California Department of Social Services (CDSS) for Fair Hearings.

All inquiries not meeting the requirements of a formal appeal shall be responded to as a correspondence, as specified in Exhibit A5.2.d of this Agreement.

b) The CalHEERS and the Contractor shall provide notice of appeal rights in all appropriate appeals correspondence to applicants/subscribers and shall assure compliance with all established timeframes, including the subscriber's right to request continuing eligibility in the CCHIP while the appeal determination is pending.

c) The Contractor shall maintain all business records of written and oral contacts with applicants, subscribers, and their representatives in a manner that will enable such records to be introduced as evidence, pursuant to Evidence Code Section 1271. The Contractor shall have the ability to respond directly to an applicant's/subscriber's authorized representative or other third party for whom the applicant/subscriber has a signed authorization on file with the Contractor. The Contractor shall forward all information necessary to determine an appeal to CDSS after being notified that an appeal has been filed. The Contractor shall work with DHCS and CDSS to ensure that all necessary information has been forwarded to CDSS for an administrative hearing.

d) The Contractor shall forward all eligibility determination appeals received to CDSS as detailed in the NOD01 (Notification Letter) received by the applicant/subscriber. Using established protocols for communications and relaying of private health information, and in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Contractor shall:

   i) For First Level Appeals- The Contractor shall assist in researching and informally resolving appeals as directed by DHCS. If necessary, the Contractor shall contact the appellant to get clarifications and additional information, as needed for research for informal resolution. "Informal resolution" means outreach to the appellant by the Contractor to resolve the issue prior to an administrative hearing. If the appellant requests enrollment/continued enrollment in the CCHIP, the Contractor shall evaluate and determine whether the appellant is entitled to receive CCHIP enrollment/continued enrollment, and if the Contractor determines that enrollment/continued enrollment is appropriate, enroll the appellant in CCHIP, respond to the appellant in writing regarding enrollment/continued enrollment in CCHIP, and notify DHCS and CDSS that the appeal has been informally resolved.

   ii) For Second Level Appeals- If the Contractor is unable to informally resolve the appeal, the Contractor shall notify DHCS and CDSS that the appeal could not be informally resolved and assist the appellant by referring his or her request for an administrative hearing on the unsuccessful resolution of the first level appeal to CDSS.

7) <u>HK Appeals</u>

a) The contractor will inform applicants/subscribers of their benefit and enrollment related appeal rights.

b) Contractor will provide notice of appeal rights in all appropriate appeals correspondence to applicants/subscribers and shall assure compliance with all established timeframes, including the subscriber's right to request continuing eligibility in the Healthy Kids Program while the appeal determination is pending.

c) Contractor shall maintain all business records of written and oral contacts with applicants, subscribers, and their representatives in a manner that will enable such records to be introduced as evidence, pursuant to Evidence Code Section 1271. The Health Coverage Unit shall have the ability to respond directly to an applicant's/subscriber's authorized representative or other third party for whom the applicant/subscriber has a signed authorization on file with Health Coverage Unit or HPSM. The HPSM shall forward all information necessary to determine an appeal to Health Coverage Unit after being notified that an appeal has been filed. The Contractor shall work with Health Coverage Unit to ensure that all necessary information has been forwarded to Health Coverage Unit for an administrative hearing.

d) The Contractor shall forward all eligibility determination appeals received to Health Coverage Unit received by the applicant/subscriber using established protocols for

communications and relaying of private health information, and in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Contractor shall assist in researching and informally resolving appeals. If necessary, the Contractor shall contact the appellant to get clarifications and additional information, as needed for research for informal resolution. "Informal resolution" means outreach to the appellant by the Health Coverage Unit/HPSM to resolve the issue prior to an administrative hearing. If the appellant requests enrollment/continued enrollment in the Healthy Kids Program, the Health Coverage Unit shall evaluate and determine whether the appellant is entitled to receive Healthy Kids enrollment/continued enrollment, and if the Health Coverage Unit determines that enrollment/continued enrollment is appropriate, HPSM shall enroll/keep enrolled the appellant in Healthy Kids. Health Coverage Unit shall respond to the appellant in writing regarding enrollment/continued enrollment in Healthy Kids, and notify the appellant and the contractor that the appeal has been informally resolved.

8) **CCHIP and HK Program Materials**
   a) The Contractor shall establish and maintain CCHIP and HK necessary Program materials in order to administer the Program, in accordance with the statutory and regulatory requirements specified in Exhibit C5 of this Agreement and as required to meet the same member informing responsibilities for HK members.
   b) The Contractor shall translate the necessary Program materials into the same languages spoken by the eligible populations that are served in the Contractor's county. To assure translation accuracy, the Contractor shall retain certified translation services to conduct initial English to non-English translation.
   c) The Contractor shall establish and maintain an adequate inventory of the CCHIP and HK necessary Program materials in the appropriate languages to serve the eligible population in the Contractor's county. The Contractor shall have the ability to replenish its inventory of the CCHIP and HK applications and necessary Program materials, whenever the supply is depleted.
   d) The Contractor shall assure that all written materials are understandable by low reading level applicants and subscribers, no higher than a sixth grade reading level.

9) **CCHIP and HK Telephone and Customer Service**
   a) The Contractor shall establish and maintain a toll-free telephone number for CCHIP and HK applicants and subscribers; the toll-free line shall be available during normal business hours, Monday-Friday 8:30 am to 5:00 pm.
   b) The Contractor shall have sufficient number of trained bilingual staff to provide customer service to the eligible population in the Contractor's county. The Contractor shall also have the capability to provide telephone services via a translation service in any other languages and TDD service for the hearing impaired.
   c) The Contractor's toll-free line shall be staffed with personnel trained to:
   d) Answer CCHIP and HK billing questions
   e) Answer other CCHIP and HK related questions

10) **CCHIP and HK System Requirements**
   a) The Contractor's systems shall maintain a CCHIP and HK family contribution income accounting subsystem with documented internal controls to track all family contribution activity for each applicant and for each eligible and enrolled subscriber for CCHIP and HK. The system shall have the ability to track initial and ongoing payments by payment type and source, such as check, cash, credit card, and any other payment source. The Contractor's system shall maintain the family contribution historical payment activity for auditing purposes.
   b) The Contractor shall establish and maintain a family contribution refund system for the CCHIP and HK, with documented internal controls that shall ensure timely, complete and

accurate processing and payment of both automated and manual refunds of family contributions. The Contractor shall ensure that a family contribution payment is verified for validity of funds prior to issuing any refund.

c) The Contractor shall have sufficient dedicated systems, operations and maintenance staff whose sole purpose shall be to assure that the Contractor's system is fully functional and complies with all the administrative requirements within this Agreement.

11) CCHIP Family Contributions

a) The Contractor shall collect CCHIP family contributions as specified in the statutory and regulatory requirements in Exhibit C5 of this Agreement, the Contractor's County requirements and as approved by CMS in the 7th California SPA, Title XXI.

b) The Contractor shall calculate the amount of CCHIP family contribution, including any rate changes, balances due, and payments made, and shall notify applicants of their required family contributions.

c) The Contractor shall refund, by check to the applicants/subscribers, family contributions from applicants/subscribers determined to be ineligible for CCHIP within six (6) weeks. Net adjustments to family contributions that result in overpayment shall be refunded to the applicant/subscriber, except when the applicant/subscriber requests a credit to his or her account.

d) The Contractor shall establish and maintain an American Indian/Alaskan Native (AI/AN) family contribution exemption in accordance with the statutory and regulatory requirement specified in Exhibit C5 of this Agreement.

12) HK Family Contributions

a) The Contractor shall collect HK family contributions as specified in the statutory and regulatory requirements in Exhibit C5 of this Agreement, the Contractor's County requirements and as approved by CMS in the 7th California SPA, Title XXI.

b) The Contractor shall calculate the amount of HK family contribution, including any rate changes, balances due, and payments made, and shall notify applicants of their required family contributions.

c) The Contractor shall refund, by check to the applicants/subscribers, family contributions from applicants/subscribers determined to be ineligible for HK within six (6) weeks. Net adjustments to family contributions that result in overpayment shall be refunded to the applicant/subscriber, except when the applicant/subscriber requests a credit to his or her account.

d) The Contractor shall establish and maintain an American Indian/Alaskan Native (AI/AN) family contribution exemption in accordance with the statutory and regulatory requirement specified in Exhibit C5 of this Agreement.

13) Contractor Responsibilities - Health Care Covered Services and Benefits

a) The Contractor is responsible for all aspects of the administration and provision of covered health care services including health, dental, and vision benefits as specified in the HFP regulations. The Contractor shall purchase the covered health care services required through subcontracted DMHC or DOI licensed HCSPs. These responsibilities include maintaining privacy and security of applicant information and subscriber information; enrollment of eligible subscribers; disenrollment of ineligible subscribers; receipt of enrollment data from Contractor's plans transmission of enrollment data to healthcare providers; assigning primary care providers when applicable; providing plan ID cards, plan provider directories and plan evidence of coverage booklets; administering plan grievance procedures; administering cultural and linguistic services; administering Serious Emotional Disturbance (SED) benefits; administering subscriber co-payments; administering clinical quality measures and management practices; development and maintenance of plan data systems; maintaining plan toll-free telephone line; and providing plan customer service.

i) HCSP

1. This Agreement is entered into by the Contractor and County for the purpose of purchasing and providing health coverage for subscribers determined to be eligible for CCHIP and HK. The Contractor shall purchase covered health care services from DMHC or DOI licensed HCSPs that includes a County Organized Health System. The method of delivery of the insured health benefits shall be a health maintenance organization and/or a preferred provider organization. The Contractor, through its subcontracted plan, agrees to utilize the health maintenance organization and/or the preferred provider organization.

ii) Dental Care Service Plan

1. This Agreement is entered into by the Contractor and County for the purpose of purchasing and providing dental coverage for subscribers determined to be eligible for CCHIP and HK. The Contractor shall purchase health covered services from DMHC or DOI licensed HCSPs. The method of delivery of the insured dental benefits shall be a dental maintenance organization and/or a preferred provider organization. The Contractor, through its subcontracted plan, agrees to utilize the dental maintenance organization and/or the preferred provider organization.

iii) Specialized HCSP

1. This Agreement is entered into by the Contractor and County for the purpose of purchasing and providing vision coverage for subscribers determined to be eligible for CCHIP and HK. The Contractor shall purchase health covered services from DMHC or DOI licensed HCSPs. The method of delivery of the insured vision benefits shall be a specialized HCSP. The Contractor, through its subcontracted plan, agrees to utilize the specialized HCSP.

iv) Geographic Areas Covered

1. The Contractor's participation in CCHIP and HK is limited to enrollment of Program subscribers who reside in the Contractor's plans' CCHIP licensed service area accepted by DHCS. The geographic area is San Mateo County, California.

2. The Contractor shall ensure that the CCHIP geographic coverage shall be the same geographic coverage as was provided for the HFP.

v) Changing Health Care Providers

1. The Contractor shall ensure that the Contractor's plans have an adequate network of providers to provide services to CCHIP and HK subscribers and shall establish a mechanism to ensure adequate access to the providers. These providers (institutional and professional) are listed in the Contractor's plans' Provider Directories. The Contractor agrees to provide copies of the Provider Directories to County upon request.

2. Health, dental, and specialized (vision) care providers shall be deemed added to or deleted from the Contractor's plans Provider Directories as contracts between the Contractor's plans and health, dental, and specialized (vision) care providers begin or end.

3. The Contractor agrees to maintain the availability of those providers listed at any time during the benefit year in the Contractor's plans' Provider Directories until the end of the benefit year, if elimination of the provider would impact twenty-five (25) or more subscribers enrolled with the

Contractor's plans through CCHIP or HK. For the purpose of this section, the term "provider" may refer to a solo practitioner, a provider group or a clinic.

4. Provision Appendix A5.3.v.3 above shall not apply if the withdrawal of a provider from the Contractor's plan's network was done at the request of the provider or is part of the Contractor's plan's activities to obtain or retain National Committee for Quality Assurance (NCQA)/Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) accreditation, or is initiated by the Contractor's plan for cause.

vi) Eligibility

1. All subscribers who are determined CCHIP or HK eligible are eligible to enroll in a health, dental, and specialized (vision) plan. The Contractor certifies that its enrollment process will not be prejudicial to the participating health, dental, and specialized (vision) plans.

vii) Conditions of Enrollment

1. The Contractor shall ensure that the Contractor's health, dental, and specialized (vision) plans shall enroll all CCHIP and HK eligible subscribers on the effective date of coverage specified by the Contractor.

2. In accordance with the statutory and regulatory requirements specified in Exhibit C5 of this Agreement, the Contractor shall complete the enrollment process within ten (10) calendar days of receipt of the DEF or Add-a-Person Form, unless the Contractor is waiting for necessary information pursuant to Subsection 2699.6606(b)(1) and (2) or is requesting information pursuant to Subsection 2699.6600(c)(1)(BB)(1). For those affected applications, the Contractor shall complete the application review process within twenty (20) calendar days of receipt of the DEF or Add-a-Person Form.

viii) Disenrollment

1. The Contractor shall ensure that the Contractor's health, dental, and specialized (vision) plans shall disenroll subscribers when notified to do so by the Contractor on the date specified by the Contractor.

2. In no event shall any individual subscriber be entitled to the payment of any benefits with respect to health, dental, and specialized (vision) care services rendered, supplies or drugs received or expense incurred following termination of coverage consistent with state and federal law. For the purposes of this Agreement, a charge shall be considered incurred on the date the service or supply giving rise to the charge is rendered or received.

ix) Commencement of Coverage

1. Coverage shall commence for a subscriber at 12:01 a.m. on the day designated by the Contractor as the effective date of coverage.

x) Identification Cards, Provider Directory, and Evidence of Coverage

1. The Contractor shall assure health, dental, and specialized (vision) plans, no later than the effective date of coverage, issue to the parent(s) or guardian(s) of the newly eligible subscriber(s), an Identification Card, Provider Directory, and Evidence of Coverage booklet setting forth a statement of the services, benefits, and grievance procedure to which the subscriber is entitled. The Contractor agrees that the materials sent to the parent(s) or guardian(s) of the newly eligible subscriber(s) shall also include information regarding how subscribers are to access services. The information shall be in addition to

the description provided in the Evidence of Coverage booklet. Examples of acceptable forms of information include, but are not limited to: a brochure on How to Access Services, inclusion in a cover letter of the specific pages in the Evidence of Coverage booklets relating to accessing services, or a magnet listing the telephone numbers to call to schedule an appointment with providers.

2. The Contractor shall ensure that fifteen (15) calendar days prior to the start of a new benefit year the parent(s) or guardian(s) of the subscribers enrolled in the Contractor's plan shall be issued an updated Evidence of Coverage booklet setting forth a statement of the services and benefits to which the subscriber is entitled in the next benefit year.

3. The Contractor shall ensure that the Provider Directories are updated and distributed by the Contractor's plans to parent(s) or guardian(s) on behalf of subscribers whenever there is a material change in the Contractor's plans' provider networks.

4. The Contractor's Provider Directories shall indicate the language capabilities of the providers.

5. The Contractor shall provide copies of the Contractor's plans' Evidence of Coverage booklets and Provider Directories to any person requesting such materials, by telephone or in writing, within ten (10) calendar days of the request.

6. The Contractor shall send DHCS, upon request; copies of the Contractor's plans updated Evidence of Coverage Booklets and updated Provider Directories.

7. Written informational material provided to parent(s) or guardian(s) of subscribers shall be no higher than a sixth grade reading level and that is approved by DHCS, to the extent that compliance with this provision does not conflict with regulatory agency directives or other legal requirements.

xi) Primary Care Provider Assignment (HMOs and DMOs only)

1. The Contractor, , agrees to ensure that all subscribers shall be enrolled with a primary care physician within thirty (30) days of the effective date of coverage in the plan. The Contractor shall provide the Contractor's health and dental plans with the name of each subscriber's chosen primary care provider, if the name of the primary care provider is listed on the CCHIP or HK application. If the Contractor assigns a primary care provider to a subscriber, the Contractor shall use a fair and equitable method of assignment from the Contractor's plans' provider networks and shall promptly notify subscribers of the selection and of the opportunity to change the assigned primary care providers. The method of assignment shall take into account the geographic accessibility and language capabilities of providers. The Contractor shall ensure that the Contractor's plans notify the primary care providers promptly that they have been chosen by the subscriber or assigned by the Contractor's plan.

2. Whenever the Contractor assign a subscriber to a group or clinic, the Contractor shall ensure that the Contractor' notifies the subscriber of his or her right to select a new primary care provider immediately or at any future time, including such time as the selected primary care provider is no longer

affiliated with the clinic. The Contractor shall ensure that the Contractor's plans notify the subscriber of his or her rights immediately after the assignment to the clinic has been made.

xii) Right to Services

1. Possession of the Contractor's Plan Identification Cards confers no right to services or other benefits of the CCHIP. To be entitled to services or benefits, the holder of the card must, in fact, be a subscriber enrolled in the CCHIP. Therefore, any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Agreement, including the law specified in Exhibit C5, is personally responsible for the cost of all health care services.

2. Possession of the Contractor's Plan Identification Cards confers no right to services or other benefits of HK. To be entitled to services or benefits, the holder of the card must, in fact, be a subscriber enrolled in the HK. Therefore, any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Agreement is personally responsible for the cost of all health care services.

xiii) Enrollment Data

1. The County and the Contractor agree to the following regarding the transmission, receipt, and maintenance of enrollment data.

2. The Contractor shall transmit subscriber enrollment and disenrollment information, subscriber data updates, as well as transfer and reinstatement information, to the Contractor using EDI. The Contractor shall ensure that the Contractor's plans accept the information via EDI. The Contractor shall receive the transmitted information, data and file sent through the EDI in a manner and format that comply with HIPAA standards for electronic transactions and code sets.

3. The Contractor shall accept written confirmation of enrollments from the County, in the event that system errors cause enrollment transactions to be delayed. The Contractor agrees that the written confirmations are valid and acceptable alternative notifications to the Contractor until the failed or delayed enrollment transaction can be generated and sent to the Contractor'.

4. The Contractor shall provide EDI instructions and data mapping formats to the Contractor upon request. The County shall provide additional technical assistance to Contractor in order to establish electronic capability.

xiv) Traditional and Safety Net Providers

1. The Contractor shall establish, with traditional and safety net providers as described in Article 4 of the HFP regulations, network membership and payment policies that are no less favorable than its policies with other providers.

xv) Public Awareness

1. The Contractor shall obtain approval of all public awareness efforts by the Countyr before being released in public and must be in compliance with the requirements of the Knox-Keene HCSP Act of 1975, including amendments and applicable regulations.

2. The Contractor may not directly, indirectly, or through its agents, conduct in person, door to door, mail or telephone solicitation of applicants for enrollment and is prohibited from these activities.

3. The Contractor shall ensure that the Contractor's plans' marketing shall be in compliance with all applicable statutes and regulations as specified in Exhibit C-5 of this Agreement.

xvi) Telephone Customer Service for Plan Subscribers

1. The Contractor shall provide a toll free telephone number for applicant and subscriber plan inquiries and provide all of their subscribers with this telephone number. This telephone service shall be available on regular business days from the hours of 8:30 a.m. to 5:00 p.m. Pacific Standard Time. The Contractor's plans shall provide staff bilingual in English and Spanish during all hours of telephone service. The Contractor's plans shall have the capability to provide telephone services via an interpretive service for all limited English proficient (LEP) persons.

xvii) Grievance Procedures

1. CCHIP

(i) DMHC Licensees:

1. The Contractor shall establish grievance procedures to resolve issues arising between themselves and subscribers or parent(s) or guardian(s) acting on behalf of subscribers. The Contractor's plans processes shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by Contractor's plans licensing statute, the Knox-Keene HCSP Act of 1975, as amended. These procedures shall be described in the Contractor's plans Evidence of Coverage booklet.
2. The Contractor shall report to the County and DHCS by February 1 of each year, in a format determined by DHCS, the number and types of benefit grievances filed by subscribers and by parent(s) or guardian(s) acting on behalf of subscribers in the previous calendar year in the CCHIP. Benefit grievances include, but are not limited to, complaints about waiting time for appointments, timely assignment to a provider, issues related to cultural or linguistic sensitivity, difficulty with accessing specialists and the administration and delivery of health care benefits in the CCHIP

(ii) DOI Licensees:

1. The Contractor shall establish grievance procedures to resolve issues arising between themselves and subscribers or parent(s) or guardian(s) acting on behalf of subscribers. The Contractor's processes shall include all features required for health care, dental, and/or specialized service plans pursuant to the Knox-Keene HCSP Act of 1975, as amended, and shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by the Knox-Keene Act. These procedures shall be described in the Contractor's plans' Certificate of Insurance booklet.
2. The Contractor shall report to the Contractor, County and DHCS by February 1 of each year, in a format determined by DHCS, the

number and types of CCHIP benefit grievances filed by subscribers and by parent(s) or guardian(s) on behalf of subscribers in the previous calendar year in the Program. Benefit grievances include, but are not limited to, complaints about waiting time for appointments, timely assignment to a provider, issues related to cultural or linguistic sensitivity, difficulty with accessing specialists and the administration and delivery of health care benefits in the CCHIP.

2. HK

(i) DMHC Licensees:

3. The Contractor shall establish grievance procedures to resolve issues arising between themselves and subscribers or parent(s) or guardian(s) acting on behalf of subscribers. The Contractor's plans processes shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by Contractor's plans licensing statute, the Knox-Keene HCSP Act of 1975, as amended. These procedures shall be described in the Contractor's plans Evidence of Coverage booklet.
4. The Contractor shall report to the County and HCU by February 1 of each year, in a format determined by HCU, the number and types of benefit grievances filed by subscribers and by parent(s) or guardian(s) acting on behalf of subscribers in the previous calendar year in the HK. Benefit grievances include, but are not limited to, complaints about waiting time for appointments, timely assignment to a provider, issues related to cultural or linguistic sensitivity, difficulty with accessing specialists and the administration and delivery of health care benefits in the HK program.

(ii) DOI Licensees:

3. The Contractor shall establish grievance procedures to resolve issues arising between themselves and subscribers or parent(s) or guardian(s) acting on behalf of subscribers. The Contractor's processes shall include all features required for health care, dental, and/or specialized service plans pursuant to the Knox-Keene HCSP Act of 1975, as amended, and shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by the Knox-Keene Act. These procedures shall be described in the Contractor's plans' Certificate of Insurance booklet.
4. The Contractor shall report to the Contractor, County and HCU by February 1 of each year, in a format determined by DHCS, the number and types of HK benefit grievances filed by subscribers and by parent(s) or guardian(s) on behalf of subscribers in the previous calendar year in the Program. Benefit grievances include, but are not limited to, complaints about waiting time for appointments, timely assignment to a provider, issues related to cultural or linguistic sensitivity, difficulty with accessing specialists and the administration and delivery of health care benefits in the HK program.

(2)

xviii) Cultural and Linguistic Services

3. Linguistic Services

   (i) The Contractor shall ensure that their providers comply with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80), which prohibits recipients of federal financial assistance from discriminating against persons based on race, color or national origin. This is interpreted to mean that a LEP individual is entitled to equal access and participation in federally funded programs through the provision of bilingual services.

   (ii) The Contractor shall provide twenty-four (24) hour access to interpreter services for all LEP subscribers seeking health services within the Contractor's plans provider networks. The Contractor's shall use face-to-face interpreter services, if feasible. If face-to-face interpreter services are not feasible, the Contractor's may use telephone language lines for interpreter services. The Contractor shall develop and implement policies and procedures for ensuring access to interpreter services for all LEP subscribers, including, but not limited to, assessing the cultural and linguistic needs of its subscribers, training of staff on the policies and procedures, and monitoring its language assistance program. The Contractor shall ensure that the Contractor's plans' procedures include ensuring compliance of any subcontracted providers with these requirements.

   (iii) The Contractor shall ensure that when the need for an interpreter has been identified by the provider or requested by a subscriber, the Contractor's plans provide a competent interpreter for scheduled appointments. The Contractor shall ensure that the Contractor's plans avoid unreasonable delays in the delivery of health care services to persons of limited English proficiency. The Contractor shall ensure that the Contractor's plans instruct the providers within the plan's provider networks to record the language needs of subscribers in the medical record.

   (iv) The Contractor shall ensure that their providers do not require or encourage subscribers to utilize family members or friends as interpreters. After being informed of his or her right to use free interpreter services provided by the Contractor, a subscriber may use an alternative interpreter of his or her choice at his or her cost. The Contractor shall encourage the use of qualified interpreters. Minors shall not be used as interpreters except in the most extraordinary circumstances, such as medical emergencies. The Contractor shall document the request or refusal of language or interpreter services in the medical records of providers in the Contractor's provider networks.

   (v) The Contractor shall inform subscribers of the availability of linguistic services. Information provided to subscribers regarding interpreter services shall include but not be limited to: the availability of interpreter services to subscribers at no charge; the right not to use family members or friends as interpreters; the right to request an interpreter during discussions of medical information such as diagnoses of medical conditions and proposed treatment options and during explanations of plans of care or other discussions with providers; the right to receive subscriber materials; and the right to file a complaint or grievance if linguistic needs are not met.

(vi) The Contractor shall have appropriate bilingual proficiency at medical and non-medical points of contact for providers who list their bilingual capabilities in provider directories. Medical points of contact include advice and urgent care telephone lines and face-to-face encounters with providers who provide medical or health care advice to members. Non-medical points of contact include member/customer service, plan or provider office reception, appointment services, and member orientation sessions.

(vii) The Contractor shall identify and report the on-site linguistic capability of providers and provider office staff through the plans provider directories.

xix) Translation of Written Materials

1. The Contractor shall translate written informing materials for subscribers including, but not limited to: the Evidence of Coverage booklet; form letters; notice of action letters; consent forms; letters containing important information regarding participation in the health plan; notices pertaining to the reduction, denial, modification, or termination of services; notices of the right to appeal such actions or that require a response from subscribers; notices advising LEP subscribers of the availability of free language assistance services; other outreach materials; and medical care reminders. Written informing materials for subscribers shall be provided a no higher than a sixth grade reading level, to the extent that compliance with this requirement does not conflict with regulatory agency directives or other legal requirements. Translation of these materials shall be in the same languages that serve the eligible population in the Contractor's county". The Contractor shall ensure that members who are unable to read the written materials that have been translated into non-English languages have an alternate form of access to the contents of the written materials.

2. The Contractor shall validate the quality of the translated material. The Contractor shall use different qualified translators during sequential levels of the translation process to ensure accuracy, completeness, and reliability of translated materials. The Contractor shall include in the translation process the use of qualified translators for translating and editing, proofreading, and professional review.

3. Upon request, the Contractor shall submit to the Contractor and DHCS one copy of all materials routinely provided to new subscribers pursuant to this Agreement for each language in which the materials are translated.

xx) Operationalizing Cultural and Linguistic Competency

1. The Contractor shall develop internal systems that meet the cultural and linguistic needs of its CCHIP and HK subscribers. The Contractor shall ens provide initial and continuing training on cultural competency to staff and providers. Ongoing evaluation and feedback on cultural competency training shall include, but not be limited to, feedback from subscriber surveys, staff, providers, and encounter/claims data.

2. The Contractor shall ensur report to the County and DHCS upon request, the linguistically and culturally appropriate services provided and proposed to be provided to meet the needs of limited-English proficient CCHIP/HK applicants and subscribers. This report shall address types of services including, but not limited to, linguistically and culturally appropriate providers and clinics available; interpreters; marketing materials; information packets; translated

written materials; referrals to culturally and linguistically appropriate community services and programs; and training and education activities for providers. The Contractor shall en also report their efforts to evaluate cultural and linguistic services and outcomes of cultural and linguistic activities as part of the Contractor's ongoing quality improvement efforts. Reported information may include member complaints and grievances, results from membership satisfaction surveys, and utilization and other clinical data that may reveal health disparities as a result of cultural and linguistic barriers.

xxi) Covered and Excluded Benefits

1. Except as required by any provision of applicable law, only those benefits described in Article 3, Sections 2699.6700 through 2699.6723, of the HFP regulations shall be covered benefits under the terms of this Agreement. Except as required by any provision of applicable law, those benefits excluded in Article 3 of the HFP regulations shall not be covered benefits. The Contractor shall ensure that the Contractor's plans shall set out the plan of coverage in an Evidence of Coverage booklet.

2. The parties understand that terms of coverage under this Agreement are to be set forth in the Contractor's Evidence of Coverage booklets. In the case of conflicts, terms of coverage set forth in the Evidence of Coverage booklets shall be binding only when they are more favorable to the subscriber notwithstanding any provisions in this Agreement that are less favorable to the subscriber.

3. The Contractor shall make benefit and coverage determinations. All such determinations shall be subject to the Contractor's grievance procedures.

xxii)CCS

1. The Contractor shall ensure identify subscribers with a suspected California Children's Services (CCS) condition and shall refer them to the local CCS Program for a full determination of residential, medical, and financial eligibility. Once CCS eligibility is determined as defined in Title 22, CCR, Division 2, Subdivision 7, Chapter 3, medically necessary services to treat a CCHIP or HK subscriber for a CCS eligible condition shall be provided by the local CCS Program. The Contractor shall provide all medically necessary services including the treatment of CCS conditions when the CCHIP or HK subscriber does not meet the CCS eligibility requirements to the extent that they are covered services under the Optional Targeted Low-Income Children's Program. The Contractor shall provide the parent(s) or guardian(s) acting on behalf of the subscriber referred to CCS with a CCS one page (double sided) informational flyer. DHCS agrees to provide the Contractor with camera-ready copies of the CCS informational flyer.

2. The Contractor shall implement written policies and procedures for identifying and referring subscribers with suspected CCS eligible conditions to the local CCS Program. The policies and procedures shall include, but not be limited to:

   (i) Procedures for ensuring that the Contractor's providers are informed of the identity of CCS paneled providers and CCS approved hospitals within the Contractor's entire network.
   (ii) Policies and operational controls that ensure that the Contractor's providers perform appropriate baseline health assessment and

diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a subscriber has a CCS eligible medical condition.

(iii) Policies and procedures to assure that the Contractor's providers refer potentially eligible children to the CCS Program.

(iv) Procedures that provide for continuity of care between the Contractor's providers and CCS providers.

3. The Contractor shall annually report to DHCS, County and Contractor the number of CCHIP and HK subscribers who were referred to the local CCS Program. The first report is due thirty (30) calendar days following the end of the first year of CCHIP implementation under this Agreement.

4. Until eligibility for the CCS Program is established, the Contractor shall continue to be responsible for arranging for the delivery of all covered medically necessary health care and case management services for a subscriber referred to CCS. Services that are provided by a CCS paneled provider or approved facility on the date of referral, or afterwards, and that are authorized by the CCS Program for a CCS eligible child, shall be paid through the CCS Program at the CCS reimbursement rate retroactively to the provider of the services.

5. Once eligibility for the CCS Program is established for a subscriber:

   (i) The Contractor shall continue to provide covered primary care and all other medically necessary covered services other than those provided through the CCS Program for the CCS eligible condition and shall ensure the coordination of services between its primary care providers, the CCS specialty providers, and the local CCS Program.

   (ii) The CCS Program shall authorize and pay for the delivery of medically necessary health care services to treat a subscriber's CCS eligible condition. The CCS authorization, on determination of eligibility, shall be to CCS paneled providers and approved facilities, some of which may also be members of the Contractor's network. Authorization normally cannot predate the initial referral to the local CCS Program in accordance with Title 22, CCR, Section 41770. Claims for authorized services shall be submitted to the appropriate CCS office for approval of payment.

   (iii) For the purposes of Appendix A5.3.xx.5.b, above, initial referral means referral by a Contractor's plans' network physician, or by any other entity permissible under CCS regulations.

xxiii) Mental Health: Family Members

1. The Contractor agrees to involve appropriate family members in the mental health and/or substance abuse services provided to a subscriber who has experienced family dysfunction and/or trauma to the extent it is required as a course of treatment for the health and recovery of the child.

xxiv) Mental Health: Services for Subscriber Children

1. The Contractor shall provide covered benefits that include mental health services in accordance with Section 1374.72 of the California Health and Safety Code, which include the provision of mental health services for children with SED or with a serious mental disorder.

xxv) Other Public Linkages

1. The Contractor shall, to the extent feasible, create viable protocols for screening and referring subscribers needing supplemental services outside of the scope of benefits described in Article 3 of the HFP regulations to public programs providing such supplemental services for which they may be eligible, as well as for coordination of care between the Contractor and the public programs. Public programs may include but not be limited to: regional centers, Women, Infants and Children Supplemental Food Program, lead poisoning prevention, and programs administered by local education agencies.

xxvi) Pre-existing Condition Coverage Exclusion Prohibition

1. No pre-existing condition exclusion period or post-enrollment waiting period shall apply to subscribers.

xxvii) Exercise of Cost Control

1. The Contractor shall enforce all contractual agreements for price and administer all existing utilization control mechanisms for the purpose of containing and reducing costs.

xxviii) Co-Payments

1. The Contractor shall impose co-payments for subscribers as described in Article 3 of the HFP regulations. The Contractor agrees that co-payment maximums as described in Article 3 of the HFP regulations shall be applied for each benefit year and shall be renewed on July 1 of each year. The Contractor shall ensure that the Contractor's Evidence of Coverage or Certificate of Insurance document describe the process to be used by parent(s) or guardian(s) acting on behalf of subscribers to document that the annual two hundred and fifty dollar ($250) out-of- pocket family maximum has been reached.

2. The Contractor shall work with its provider networks to provide for extended payment plans for subscribers utilizing a significant number of health services for which co-payments are required. When feasible, the Contractor shall instruct its provider network to offer extended payment plans whenever a family's co-payments exceed twenty-five dollars ($25) in one month.

3. The Contractor shall report the number of subscribers who meet the co-payment maximum in the previous benefit year by October 1 of each year.

4. The Contractor shall implement an administrative process that waives all co-payments for AI and AN subscribers in the Program.

xxix) Coordination of Benefits

1. The Contractor agrees to coordinate benefits with other group health plans or insurance policies for subscribers in the Program. The Contractor shall agree to work with other plans or insurers to provide no more than one-hundred percent (100%) of subscribers' covered medical expenses. The Contractor shall coordinate such that coverage provided pursuant to this Agreement is secondary to all other coverage except for Medicaid (Medi-Cal) and Medi-Cal Access Program.

xxx) Acts of Third Parties

1. If a subscriber is injured through the wrongful act or omission of another person, the Contractor shall provide the benefits of this Agreement and the

subscriber or parent(s) or guardian(s) acting on behalf of a subscriber shall be deemed:

(i) To have agreed to reimburse the Contractor to the extent of the reasonable value of services allowed by Civil Code Section 3040, immediately upon collection of damages by him or her, whether by action at law, settlement or otherwise, provided that the subscriber is made whole for all other damages resulting from the wrongful act or omission before the Contractor is entitled to reimbursement; and

(ii) To have provided the Contractor' with a lien to the extent of the reasonable value of services provided by the Contractor' and allowable under Civil Code Section 3040, provided that the subscriber is made whole for all other damages resulting from the wrongful act or omission before the Contractor is entitled to reimbursement. The lien may be filed with the person whose act caused the injuries, his or her agent, or the court.

xxxi) Workers' Compensation Insurance

1. If, pursuant to any Workers' Compensation or Employer's Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of health services provided by the Contractor', then the Contractor shall ensure that the Contractor' provide the benefits of this Agreement and the subscriber shall be deemed to have provided the Contractor' with a lien on such Workers' Compensation medical benefits to the extent of the reasonable value of the services provided by the Contractor. The lien may be filed with the responsible third party, his or her agency, or the court. For purposes of this subsection, reasonable value shall be determined to be the usual, customary or reasonable charge for services in the geographic area where the services are rendered.

xxxii) Use of Subcontractors

1. The Contractor may, in its discretion, use the services of subcontractors to recover on the liens provided for under Appendix A5.3.xxvii and xxix of this Exhibit. The subcontractor's compensation may be paid out of any lien recoveries obtained. DHCS understands and agrees that lien recoveries are chargeable with a prorata contribution toward the injured person's attorney fees under the Common Fund Doctrine. The Contractor may compromise liens as may be reasonable and appropriately consistent with normal business practices.

xxxiii) Health Insurance Portability and Accountability Act of 1996 Conformity

1. DHCS and the Contractor understand that the coverage provided pursuant to this Agreement constitute creditable coverage pursuant to the federal Health Insurance Portability and Accountability Act of 1996. The Contractor shall issue the Certificates of Coverage for disenrolled subscribers.

xxxiv) Interpretation of Coverage

1. The Contractor shall ensure that the Contractor's Evidence of Coverage booklet provides clear and complete notice of terms of coverage to CCHIP and HK subscribers. In the event of ambiguity regarding terms of coverage, the Contractor shall ensure that the Contractor interprets those terms in the interest of the subscriber. In the event of ambiguity regarding an exclusion from coverage, the Contractor shall interpret the language of the exclusion in

the interest of the subscriber. Nothing in this provision shall supersede the common law rules for interpretation of insurance contracts.

xxxv) Measuring Consumer Satisfaction

1. To the extent that the Contractor elects to conduct consumer satisfaction surveys, the results of the surveys shall be made available to County and DHCS for informational purposes.

xxxvi) Standards Designed to Improve the Quality of Care

1. The Contractor assures County and DHCS that the Contractor's plans' providers shall use, and the Contractor shall monitor, the most recent recommendations of the American Academy of Pediatrics with regard to Recommendations For Preventative Pediatric Health Care and the most recent version of the Recommended Childhood Immunization Schedule/United States, adopted by the Advisory Committee on Immunization Practices.

2. The Contractor shall notify the parent(s) or guardian(s) of all subscriber children enrolled in Contractor' through the CCHIP or HK, on an annual basis, of the recommended schedule of preventive care visits.

xxxvii) Quality Management Processes

1. The Contractor shall maintain a system of accountability for quality improvement activities, including participation of the governing body of the Contractor's organization, the designation of a Quality Improvement Committee, supervision of the activities of the Medical Director, and the inclusion of contracted physicians and other providers in the Contractor's process of Quality Improvement development and performance. Evidence of such activities shall be provided to DHCS upon request.

2. The Contractor's Quality Management processes have been reviewed and found to be satisfactory by one of the following review organizations: The JCAHO, the NCQA, or the California DMHC.

Exhibit B5

In consideration of the services provided by Contractor described in Exhibit A5 and subject to the terms of the Agreement, County shall pay Contractor based on the following fee schedule and terms:

1) Premium Schedule

Premium Schedule for January 1, 2011 through June 30, 2015 is $101.02 per Member per Month for infants and children.

Per Resolution Numbers 075471 and 075586 authorizing an agreement with the California Department of Health Care Services to provide funding for the County Children's Health Initiative Program, rates provided after July 1, 2015 are confidential, and are not available until, at the earliest July 2, 2019. See Exhibit E, Item 8. of CDPH Agreement 15-92349 for the standards governing confidentiality.

2) Premium Payment

Contractor will invoice the County quarterly, delineating the premium payment amount due.

Total Quarterly Premium Amount is payable to Contractor at Contractor's corporate office by electronic file transfer via ACH, wire transfer, or check via mail addressed to: Director of Finance, Health Plan of San Mateo, 801 Gateway Blvd, Suite 500, South San Francisco, CA 94080. The Quarterly Premium Amount is due by the last work day of January, April, July, and October. In the event Contractor submits a Membership Report to County later than the first (1st) working day of a quarter, the Total Quarterly Premium Amount will be due no later than thirty (30) calendar days after receipt of the Membership Report by County.

3) Premium Calculation, Due Date, and Grace Period

a) The Contractor shall submit to the County a Membership Report by the first (1st) working day of each quarter. This report shall include the Actual Quarterly Premium Due (based on the number of actual member months of coverage for the previous quarter) and an Estimated Quarterly Premium Due (based on a projection of member months to be covered during the previous quarter).
b) Premiums shall be paid prospectively for the estimated number of member months of coverage for the current quarter. The Estimated Quarterly Premium Due shall be adjusted based on the difference between the Actual Quarterly Premium Due for the last quarter and the Estimated Quarterly Premium Due paid by County for the last quarter.
c) For the first month or partial month of a Member's coverage, the County will pay one hundred percent (100%) of the Premium for Members with effective dates of coverage on the first (1st) through the sixteenth (16th) day of the month. No Premium will be paid for the first partial month of coverage for Members whose coverage begins on the seventeenth (17th) through the last day of the month of partial coverage.
d) The County will pay premiums to Contractor as billed by Contractor. However, in the event of a disagreement as to the amount owed, the County will communicate discrepancies to the Contractor, which will make an effort to resolve any discrepancy noted by the next billing period. Premium adjustments due to discrepancies will be incorporated into the next Total Quarterly Premium Amount due.

4) Retroactive Additions and Credits for Member Terminations

a) Retroactive additions will be honored at the discretion of the Contractor based upon the eligibility guidelines in the Evidence of Coverage. Newborn infants maybe retroactively added back to their date of birth if the mother applies before the date of birth. Retroactive additions are subject to payment of all applicable Premiums and may be subject to all applicable Family Contributions.

b) Retroactive terminations of Members will be honored at the discretion of the Contractor. The County may receive credit for Premium related to a retroactive termination, but the Contractor will not honor terminations for a period greater than sixty (60) days prior to the date of notification. The Premium amount credited to the County will be based on the effective date of termination; information regarding credits due to retroactive terminations will be included in the Membership Report.
c) The County shall be responsible to pay the Contractor Premiums for any eligible Members forwarded to Contractor to the extent Contractor enrolled these Members and paid claim(s) based on the Human Services Agency's representation that the Member was eligible, when coverage was not actually valid.
d) The County shall be responsible to pay the Contractor Premiums up to a maximum of two months if a Responsible Party fails to pay an eligible Member's Family Contribution.

5) Family Contribution

a) The Children's Health Initiative Oversight Coalition and the Authority sets the Family Contribution amount per Member per Quarter for HK in alignment with the Family Contribution schedule for CCHIP delineated in Section 11 above. The family contribution shall be $0, $12, $39, $63 or $150 per quarter, based on the Member's family size and family income as determined through the application process.
b) The amount of the Family Contribution is determined at the time of application and the Responsible Party shall choose whether the Family Contribution will be paid on an annual or quarterly basis. As an incentive of Members to make Family Contribution payments on an annual basis rather than a quarterly basis, annual payments will be computed on the basis of three times the quarterly payment amount, i.e., Members who pay for three quarters at once will have the fourth quarter's Family Contribution requirement waived.
c) The Health Coverage Unit of the San Mateo County Health System will determine whether a Responsible Party is eligible for either a total or partial reduction of the Family Contribution. The HSA transmit information concerning changes in the amount of Family Contribution to the Contractor with the eligibility record.
d) The Responsible Party will be notified at the point of application and in all communications that all payments of the Family Contribution should be made to the Contractor. The Contractor will invoice the Responsible Party for either quarterly or annual payment related as determined at application or redeterminations. If payment is received prior to invoicing, the Contractor will retain and apply payments as appropriate.
e) To prevent disenrollment due to nonpayment, the Contractor will exercise its best efforts to contact the member by phone or mail. As appropriate, the Contractor will notify the Health Coverage Unit of the San Mateo County Health System if the Responsible Party requests Family Assistance.
f) If all efforts to obtain the Family Contribution payment have proven to be unsuccessful, the Contractor will disenroll the Member effective the last day of the second month of the quarter for which the Family Contribution has not been made. The County's obligation to pay Premiums on a Member's behalf shall be limited to two month's premium for a Member whose Responsible Party has not made Family Contribution, and Contractor shall not be obligated to provide services for the Member for more than tow months without payment of the Family Contribution. The Contractor will notify the Responsible Party of the Member's termination date due to nonpayment of the Family Contribution at least 15 days prior to the date of disenrollment.

Contractor will remit the Family Contribution amounts collected to the County by electronic file transfer via ACH, wire transfer, or check via mail addressed to: Director of Health Coverage Unit, Family Health Services, 2000 Alameda de las Pulgas, Suite 230, San Mateo CA 94403. The Family Contribution payment is due by June 15th at the latest.

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Exhibit C5 - Act and Regulation

This Agreement is in accord with and pursuant to Section 15850 et seq., Chapter 3 of Part 3.3 of Division 9 of the California Welfare and Institutions Code that continues the County Health Initiative Matching (CHIM) Fund, which provides funding for the CCHIP. This Agreement is also in accord and pursuant to Title XXI of the Social Security Act, Public Law 105-33 and its implementing federal regulations, which establish the State Children's Health Insurance Program (S-CHIP) and which provide authorization and federal funding for CCHIP and the Optional Targeted Low Income Children's Program (OTLICP). Title 10, Chapter 5.8 of the California Code of Regulations, which was adopted by the Managed Risk Medical Insurance Board to implement the Healthy Families Program (HFP), governs the OTLICP and shall hereinafter be called the HFP Regulations. The HFP program has been transitioned to DHCS and is now known as the OTLICP. Terms and conditions used in the HFP Regulations shall have the same and identical meanings in this Agreement. The CCHIP develops Program materials; receives and downloads a Daily Extract File (DEF) from DHCS, which contains a listing of applicants that are determined Eligible or Conditionally Eligible for CCHIP via the Single Streamlined Application (SSA); processes applications; conducts eligibility determinations; enrolls eligible applicants; and provides health, dental, and vision health coverage to S-CHIP eligible subscribers. Effective March 23, 2010, in accordance with the Affordable Care Act (ACA) of 2010, and under its Maintenance of Effort (MOE) provision to receive federal Medicaid funds, the State cannot impose eligibility and enrollment policies that are more restrictive than those in place at the time the ACA was enacted until 2019 for children in Medicaid and CHIP. This Agreement is for the purpose of administering the CCHIP and providing the eligible contractors access to federal funding through the CHIM Fund.